IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. BUTCH OTTER, GOVERNOR
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 24, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

RE: St. Luke's Regional Medical Center, provider #130006

Dear Mr. Fletcher:

This is to advise you of the findings of the complaint investigation, which was concluded at your facility on November 19, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies. The hospital is under no obligation to provide a plan of correction for Medicare deficiencies. If you do choose to submit a plan of correction, provide it in the spaces provided on the right side of each sheet.

Also enclosed is a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

Please sign and date both of the forms and return them to our office by **December 7, 2009**. Keep a copy for your records. For your information, the Statement of Deficiencies is disclosable to the public under the disclosure of survey information provisions.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

Enclosures

St Luke's
Boise · Meridian

Nationally Recognized for Nursing Excellence

December 7, 2009

Teresa Hamblin
Sylvia Creswell
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720-0036

Sent via facsimile to (208) 364-1888

Dear Ms. Hamblin and Ms. Creswell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated November 24, 2009, advising us of the findings of your complaint investigation on November 16-19, 2009. As a Joint Commission accredited organization, we are aware we are under no obligation to provide a plan of correction for the deficiencies identified under the CMS regulations; however we are committed to reviewing and improving our processes and have prepared action plans. Attached are our responses to the Statement of Deficiencies and Plan of Correction for the findings under both the CMS and Idaho licensure regulations.

Thank you for allowing us the opportunity to respond to your findings. If you have additional questions or concerns regarding our response please feel free to contact me at 381-4475.

Sincerely,

Vickie Whitham

Vickie Whitham, RN, MS, NE-BC
Director of Safety and Accreditation

cc: Gary Fletcher, CEO
Barton Hill, MD, Vice President, Medical Affairs
Pam Bernard, COO, St. Luke's Meridian Medical Center
Chris Roth, COO, St. Luke's Boise Medical Center
Joanne Clavelle, CNO, St. Luke's Boise and Meridian Medical Center
Mary Cronin, Accreditation Manager
Monica Zelley, Patient and Family Relations Manager

St. Luke's Boise Medical Center
St. Luke's Meridian Medical Center
Gary L. Fletcher, CEO
190 East Bannock Street
Boise, Idaho 83712

www.stlukesonline.org

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS A deficiency was cited during a complaint investigation survey of your hospital. Surveyors conducting the investigation were: Teresa Hamblin, RN, MS, Team Leader Patrick Hendrickson, RN, HFS Acronyms used in this report include: ED - Emergency Department EMS - Emergency Medical Services RN - Registered Nurse	A 000		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure medical records were complete in 7 of 28 patient records (#12, #19, #20, #22, #23, #26, and #29) that were reviewed. Incomplete records were manifested by missing physician orders for mental health holds, incomplete consent forms, and failure to document discharge evaluations. Incomplete records had the potential to interfere with continuity of patient care and clarity regarding the course of consent and treatment. Findings include: 1. Missing Physician Orders for Patients on Physician Mental Health Holds:	A 450		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Vicki Whitham, RN MS	Director of Safety & Accreditation	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 1 A hospital policy, "Involuntary Protective Mental Health Hold for Adult Patients," revised 10/22/09, stated the physician would write an order to place the patient on a protective mental health hold and sign an Application for Commitment. This policy was not followed. Examples include: a. Patient #22, a 44-year-old female, presented to the ED on 2/02/09 with chest pain. A physician's "Discharge Summary," dated 2/03/09, indicated the patient was put on a mental hold to be transferred to a psychiatric facility due to expressed suicidal ideation. A physician's "Application for Commitment," dated 2/03/09 at 4:30 PM, was documented in the medical record. No separate physician's orders for a mental health hold were documented in the medical record. During an interview on 11/17/09 at 12:00 PM, the RN Clinical Supervisor for the ED reviewed the medical record and confirmed the missing documentation. b. Patient #20, a 31-year-old female, presented to the ED on 11/17/09 after an overdose of medication. A nursing note, dated 10/21/09 at 7:47 PM, documented speaking with the physician who stated the patient was on a legal hold. A social work note, dated 10/21/09 at 8:55 PM, similarly stated the attending physician had placed the patient on a physician's hold and the social worker planned to fax the hold paperwork to the Ada County Prosecuting Attorney's Office. A physician's "Discharge Summary," dated 10/22/09, documented Patient #20 was transferred to a psychiatric hospital. No physician's order for a mental health hold was documented in the medical record. During an interview, on 11/17/09 at 12:00 PM, the RN	A 450	Response to Finding #1 regarding "Missing Physician Orders for Patients on Physician Mental Health Holds" is listed below. 1. The Mental Hold policy will be updated to clarify the documentation requirements to include specifics regarding the documentation of a physician order in the medical record when the patient is placed on an involuntary mental hold. 2. This expectation will be communicated to the medical staff. 3. The expectation will also be communicated to our clinical leadership staff. Person responsible for monitoring the change: Tom Aronson, Director of Social Work, Spiritual Care, and Language Services	Feb 28, 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 2 Clinical Supervisor for the ED reviewed the record and confirmed the missing documentation. c. Patient #23, a 41-year-old male, was brought to the ED via EMS on 11/09/09 after an overdose of medication. An "Application for Commitment," dated 11/09/09 at 9:00 PM, was documented in the medical record. An "Interagency Transfer Physician Orders," dated 11/10/09, documented the patient was transferred to an inpatient mental health facility. No separate physician's order for the mental health hold was documented in the medical record. During an interview on 11/17/09 at 12:00 PM, the RN Clinical Supervisor for the ED reviewed the record and confirmed the missing documentation. d. Patient #19, a 47-year-old female, was brought to the ED on 10/04/09 after a suicide attempt. A physician's "Application for Commitment," dated 10/04/09 at 12:20 PM, was documented in the medical record. No separate physician's order for the mental health hold was documented in the medical record. During an interview on 11/17/09 at 2:20 PM, the RN Clinical Supervisor for the ED reviewed the record and confirmed the missing documentation. She speculated physicians might consider the "Application for Commitment" to be the order. The hospital failed to ensure medical records contained physician orders for patients put on mental health holds. 2. Failure to Document Discharge Planning Evaluations: Patient #12 was a 47-year-old female who was admitted to the hospital on 4/24/09 for an anterior	A 450		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 3 cervical diskectomy and discharged on 4/26/09. An RN performed a pre-screening assessment of discharge needs on 4/24/09. The results of the prescreening assessment indicated a need for further discharge evaluation due to the patient's multiple medical conditions. There was no documentation in the medical record indicating the Case Manager had evaluated Patient #12 for discharge needs. During an interview on 11/17/09 starting around 11:30 AM, Patient #12's Case Manager stated she did evaluate Patient #12 for discharge needs. After her evaluation, she concluded Patient #12 did not have any needs beyond the needs identified during evaluations by other health care members, including an occupational therapist evaluation on 4/25/09 at 11:14 AM, a physical therapy evaluation on 4/25/09 at 11:29 AM, and a social service evaluation on 4/25/09 at 11:29 AM. The Case Manager reviewed the medical record and confirmed documentation was missing to indicate she had evaluated Patient #12 for discharge needs. She explained she only charted by exception; if after evaluating a patient's discharge needs she determined the patient did not have further discharge planning needs, she did not make a note in the medical record. She explained she saw many patients and did not have time to chart in all the patient records. A hospital Policy, "[Name of Facility] Medical Record Content," dated 6/19/08, stated the patient care record would reflect an interdisciplinary process of care including the nursing process (assessment, planning, implementation, and evaluation), and the therapeutic and diagnostic activities of health care professionals providing care and services to the	A 450	Response to Finding #2 regarding "Failure to Document Discharge Planning Evaluations" is listed below. 1. Effective immediately, initial and subsequent discharge planning assessments, interventions/activities will be documented in the paper/ electronic medical record within the discharge planning section. 2. The "Discharge Planning Process and Discharge of a Patient" policy which includes the "High Risk Screening Tool for Discharge Planning" was distributed to each Case Manager on 11/30/09. 3. The "Discharge Planning Process and Discharge of a Patient" policy was updated to include more specific documentation guidelines. The revised policy will be distributed to each Case Manager. Person responsible for monitoring the change: Jordice Ohnesorge, Director of Case Management	Feb 28, 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 4 patient. Observations and treatments, and the patient's response to therapies, procedures, treatments, and care would be recorded. The hospital failed to ensure all staff documented evaluations conducted for discharge planning. 3. Incomplete Documentation of Admission Consent Forms: a. Patient #26 was a 92-year-old female who was admitted to the hospital on 11/14/09 after a fall. Her record contained a consent form for surgery and anesthesia, dated 11/14/09, that stated a verbal consent for the surgery was obtained by her husband due to her confusion. Patient #26's "Admission Consent," dated 11/14/09, stated a verbal consent was obtained by Patient #26 because the patient was too weak to sign. A "Disclosure Opt Out" consent, dated 11/14/09, also stated verbal consent was obtained but failed to indicate who gave verbal consent. During an interview on 11/17/09 starting at 2:20 PM, the hospital's Accreditation Manager explained that it would be assumed the patient gave verbal consent if it was not specifically indicated on the form. She could not explain the discrepancy between why the patient gave verbal consent at Admission and presumably for the "Disclosure Opt Out" when the husband gave verbal consent for surgery because the patient was too confused to give informed consent. b. Patient #29 was an 83-year-old female who was admitted to the hospital on 11/11/09 after a fall at home. Patient #29 had a history of significant baseline dementia per the physician's "History and Physical," dated 11/11/09. The patient's record contained an "Admission	A 450	Response to Finding #3 regarding "Incomplete Documentation of Admission Consent Forms" is listed below. 1. Patient Registration Services will update their departmental guidelines to further define how verbal consent will be documented on the admission consent form. 2. The guidelines will be used to educate staff, either through department meetings and/or electronic means. Person responsible for monitoring the change: Larry Gilley, Senior Manager for Patient Access Services.	Jan 11, 2010

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 450	Continued From page 5 Consent," dated 11/11/09, and a "Disclosure OPT-OUT," dated 11/11/09, indicating verbal consent was obtained. Neither consent form documented who gave the verbal consent. During an interview on 11/17/09 starting at 2:20 PM, the hospital's Accreditation Manager explained that it would be assumed the patient gave verbal consent if it was not specifically indicated. The hospital failed to ensure hospital consent forms were complete.	A 450		

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB283	16.03.14.360.12 Record Content 12. Record Content. The medical records shall contain sufficient information to justify the diagnosis, warrant the treatment and end results. The medical record shall also be legible, shall be written with ink or typed, and shall contain the following information: (10-14-88) a. Admission date; and (10-14-88) b. Identification data and consent forms; and (10-14-88) c. History, including chief complaint, present illness, inventory of systems, past history, family history, social history and record of results of physical examination and provisional diagnosis that was completed no more than seven (7) days before or within forty-eight (48) hours after admission; and (5-3-03) d. Diagnostic, therapeutic and standing orders; and (10-14-88) e. Records of observations, which shall include the following: (10-14-88) i. Consultation written and signed by consultant which includes his findings; and (10-14-88) ii. Progress notes written by the attending physician; and (10-14-88) iii. Progress notes written by the nursing personnel; and (10-14-88) iv. Progress notes written by allied health personnel. (10-14-88) f. Reports of special examinations including but	BB283	See Plan of Correction for A450/ 482.24(c) (1).	

Bureau of Facility Standards

Vickie Whitson Director Safety & Accreditation
TITLE (X6) DATE

~~LABORATORY~~ DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
BB283	Continued From page 1 not limited to: (10-14-88) i. Clinical and pathological laboratory findings; and (10-14-88) ii. X-ray interpretations; and (10-14-88) iii. E.K.G. interpretations. (10-14-88) g. Conclusions which include the following: (10-14-88) i. Final diagnosis; and (10-14-88) ii. Condition on discharge; and (10-14-88) iii. Clinical resume and discharge summary; and (10-14-88) iv. Autopsy findings when applicable. (10-14-88) h. Informed consent forms. (10-14-88) i. Anatomical donation request record (for those patients who are at or near the time of death) containing: (3-1-90) i. Name and affiliation of requestor; and (3-1-90) ii. Name and relationship of requestee; and (3-1-90) iii. Response to request; and (3-1-90) iv. Reason why donation not requested, when applicable. (3-1-90) This Rule is not met as evidenced by: Refer to Federal Tag A 450.	BB283		

FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Page Blank MW			

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 24, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003987

Allegation #1: The hospital did not honor a patient's request to have her primary physician notified of her admission to the hospital.

Findings: An unannounced survey was made to the hospital, entering on 11/16/09 and exiting on 11/19/09. During the complaint investigation, surveyors interviewed staff and reviewed medical records, grievances, policies, procedures, and patient rights information.

The hospital's "Patient Rights and Responsibilities" brochure stated when a patient was admitted to the hospital, he/she had the right to have his/her doctor notified right away.

Five medical records were reviewed that involved patients who were determined by medical staff to require transfer to a psychiatric facility to determine if the hospital notified the patients' primary physician as soon as possible after admission. Of the records reviewed, all documented attempts to reach the primary physician. In some cases, the documentation suggested the hospital was successful at reaching the primary physicians.

At other times, it appeared that a physician on-call returned calls. One example follows:

A 44 year old female presented to the ED on 2/02/09 for chest pain. She was admitted to a telemetry floor on 2/03/09 to evaluate and monitor her cardiac status and later transferred to a psychiatric facility on an involuntary protective mental health hold.

An Emergency Department report documented the patient was first triaged at 10:54 PM. The record documented a call was placed to the patient's family physician at 11:37 PM on the evening of the patient's arrival on 2/02/09. The record documented that two minutes later, at 11:39 PM, an Internal Medicine physician returned the call to the ED. The record did not state if the physician who returned the call was the "on-call" physician. At 11:48 PM the Emergency Department placed a second outgoing call to Family Practice and spoke with a Family Practice physician other than the one identified as the patient's primary Family Practice physician. The content of the conversation was not documented in the medical record.

It could not be determined the hospital failed to notify physicians of patient admissions to the hospital.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient was inappropriately put on an involuntary mental hold and transferred to a psychiatric hospital against her will.

Findings: A hospital policy, "Involuntary Protective Mental Hold for Adult Patients," dated 12/22/07, stated when the attending physician believed that the safety of the patient was at risk, due to being a danger to himself/herself, the physician would initiate an involuntary protective mental health hold. The policy defined "likely to injure self" as a substantial risk that the patient would inflict physical harm on himself/herself as evidenced by threats or attempts to commit suicide or inflict physical harm on himself/herself.

Four records were reviewed of patients who were determined by the hospital's medical staff to be at risk of harming themselves. All of the patients in the records reviewed were placed on an involuntary protective mental hold and transferred to psychiatric facilities against their wills. In all cases, the notes documented psychiatric assessments and rationales for initiating the protective holds consistent with hospital established criteria that the patients were believed to be at risk of hurting themselves.

One example, among the four reviewed, included a 44 year old female who presented to the ED on 2/02/09 with a primary complaint of chest pain. The record, explained below, indicated that three physicians and one social worker considered the patient to be at risk of suicide and in need of psychiatric care.

An Emergency Department physician's note (Physician 1), dated 2/02/09, indicated the physician requested a consultation with a social worker because the patient acknowledged being depressed and suicidal and had stated her suicidality was the real reason she had come to the hospital. She had reported having taken some medication the previous night hoping to drown in the tub and had taken medication the night of arrival to the ED in hopes of getting in a car accident.

A "Social Work Suicide Assessment," dated 2/02/09, indicated the patient was evaluated to have an extreme sense of worthlessness, hopelessness, social isolation, depression, intent to die, and environmental stress. She was scored to be a "high risk" for suicide.

A subsequent social work note, dated 2/03/09 at 12:47 AM, indicated the patient reported being suicidal and knew she needed help. She reported she had been "looking at her insurance policies" and had been depressed for "a very long time." She told the social worker that she just wanted to go to sleep and not wake up. She expressed a willingness to go to a psychiatric facility once she was medically cleared.

An admitting physician's "History and Physical" report (Physician 2), dated 2/03/09, stated the patient clearly needed psychiatric evaluation once she was medically stable to do so. The report documented the patient reported feeling depressed and had hoped to drown in her tub on at least 3 occasions including the 2 previous nights. She also reported she had hoped to have a fatal car accident on the way to the hospital.

A physician's (Physician 3) "Discharge Summary," dated 2/03/09, stated the patient was initially willing to be transferred voluntarily to a psychiatric facility. The Summary further indicated the patient later "back pedalled" from being transferred, although she did not flatly refuse. When the receiving psychiatric facility found out about her ambivalence to being admitted, they indicated to hospital staff they were not willing to accept her unless she came on a psychiatric hold because she would be a flight risk. The physician stated he did not feel she would be safe to be discharged to the community because of her expressed suicidal ideation. He, therefore, placed her on a mental hold and sent her against her will to a psychiatric facility for care.

An "Application for Commitment" for a "Physician's Hold," dated 2/03/09 at 4:30 PM by a physician (Physician 3), stated the physician believed the proposed patient was mentally ill and likely to injure herself based on the following information:

1) ingestion of medication the previous night wanting to "sleep and not wake up"; 2) patient's statement she wanted to "end it all'; 3) patient's statements she could not contract for safety; 4) patient's statements that she had constant thoughts of suicide; 5) patient's statements that she had been in the bathtub and had considered drowning three times; 6) patient's statements that she considered causing an intentional car crash to end her life.

It was determined the hospital met the criteria for placing patients on involuntary protective mental holds.

However, in reviewing the medical records, surveyors found physician orders missing for involuntary protective mental holds. As a result, the hospital was cited at Code of Federal Regulations (CFR) 482.24(c)(1) for incomplete medical records.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The hospital failed to respond to a patient's grievance to her satisfaction.

Findings: A hospital policy, "Patient Concern, Complaint, and Grievance Process," dated 6/14/09, consistent with regulatory requirements, stated in a resolution of a grievance, the hospital would provide the patient with a written notice of its decision that contained the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

In reviewing several documented grievances, it was found the hospital followed its policy in the complaints reviewed. For example, one 44-year-old female patient filed a complaint in person with the Clinical Patient Relations Specialist, on 2/06/09, after being sent by her primary physician to the hospital to file a complaint about a physician that put the patient on an involuntary mental hold during her admission on 2/02/09. The Clinical Patient Relations Specialist documented documented the patient's concerns, explained the obligation on the part of the hospital staff to follow through with legal obligations to ensure patient safety and care. In addition, she explained the process the hospital would take to review the patient's concerns. She gave the complainant (the patient) a "Patient Rights" brochure and pointed out to her that she could file a formal complaint with the Bureau of Facilities Standards.

In response to the patient's concerns, the hospital sent a letter, dated 2/12/09, explaining to the patient that her concerns had been forwarded to the medical staff office for review. It further explained reviews conducted at the medical staff level were considered peer review and the findings were maintained as privileged and confidential, and peer review information was not available for dissemination. Rather, it was used for quality improvement purposes.

The letter provided the name of the contact person in the event the patient wanted further information or assistance.

Although, the hospital's investigation and response may not have been perceived as satisfactory by all complainants, the hospital was found to be in compliance with the minimum regulatory requirements for responding to patient complaints.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 24, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004066

Allegation: The hospital was not referring Medicare patients to Home Health Agencies after surgeries requiring physical therapy services.

Findings: An unannounced visit was made to the Hospital on 11/16/09 through 11/19/09. Hospital policies, patient grievances and twenty-nine patient records were reviewed. Hospital staff were interviewed.

Of the twenty-nine records reviewed, 13 were Medicare patients. Eleven records included patients who had a surgery (e.g. orthopedic or cervical spine) that may have required the patient to have had post-discharge medical care needs.

Of the eleven records reviewed, one patient was discharged to a skilled nursing facility and seven patients were discharged with a home exercise program and a follow-up appointment with their physician. Two patients were referred to home health because they were identified by the physician as being home bound (home bound is defined as a person that is confined to their home and it would be a taxing effort for the patient to leave the home).

The two patients discharged to Home Health were provided a handout titled "Boise Meridian Home Health Care Agencies." This handout listed all the Home Health Agencies in that demographic area. In interviews with the hospital staff, it was stated that Physical Therapists, Occupational Therapists, Social Workers, Case Managers and Physiciansassessed patients to determine post-hospital needs a patient may have. Patients were given a list of agencies in their area and the patient and/or their families chose the agency.

A "Home Care Referrals by Hospital Department" log for the time period of January 2008 to September 2009 was reviewed. This documented two-thousand, eight-hundred and twenty six patient referrals were made to home health agencies.

It was determined that patients were not denied services or forced to use a specific service.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 23, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004118

An unannounced visit was made to the hospital on 11/16/09 through 11/19/09. Hospital policies, patient grievances and twenty-nine (29) patient records were reviewed. Hospital staff were interviewed.

Allegation #1: Patients were being discharged without adequate post-discharge plans.

Findings: The hospital's "Discharge Planning Process and Discharge of Patient" policy, dated 11/11/08, was consistent with federal regulations. It stated that the hospital had a process to identify patients, at an early stage (prescreening) that may have post-discharge medical needs.. The policy stated patients who were identified in the prescreening process as potentially having such needs, would receive a more comprehensive evaluation to determine what their post-discharge needs were. In interviews with the hospital staff, it was stated that Physical Therapists, Occupational Therapists, Social Workers, Case Managers and Physicians, assessed patients to determine post-hospital needs a patient may have. This was consistent with the hospital's "Discharge Planning Process and Discharge of Patient" policy. Additionally the policy stated that a discharge plan would be developed, implemented and re-evaluated for patients who were identified as having post-hospital medical needs.

Of the records reviewed, it was determined that the hospital provided adequate discharge planning for patients whose records were reviewed. For example, one patient's record documented a patient who had an anterior cervical diskectomy. The patient's discharge pre-screening, completed by a registered nurse, identified the patient had multiple co-morbidities that warranted a comprehensive discharge evaluation. Physical Therapy evaluated the patient on the patient's second post-surgical day. The evaluation documented the patient would benefit by using a four-footed cane and having a home exercise program. Physical Therapy also saw the patient one other time before discharge. The Physical Therapist's discharge note stated the patient had met her goals. She was provided written instructions and the patient stated she felt great and was excited to go home.

An Occupational Therapist also evaluated the patient on her second post-surgical day. The Occupational Therapist documented the patient was observed, and determined to be able to perform activities of daily living and had no barriers to being discharge to home.

Social Services also evaluated the patient on her first post-surgical day. She noted that the patient had developed a safety plan, had counseling resources and her church was going to provide meals. The patient was also given smoking cessation material.

According to the patient's physician's orders and discharge summary, he agreed with the above evaluations and discharge plans.

It was determined that the hospital did not discharge patients with inadequate discharge plans.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients are not provided a copy of Patient Rights.

Findings: Of the twenty-nine (29) records reviewed all contained a signed copy (patient's or family member's signature) of their rights as patients of the hospitals. The list of rights included Medicare Discharge Rights and TriCare Discharge Rights, related to premature discharge and patients' appeal rights. The records documented that patients were provided a copy of the signed document.

It was determined that the hospital did provide patients a copy of their rights.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Patients who require continued physical therapy at home were not provided with a home exercise program.

Findings: Of the twenty-nine records reviewed, it was determined that adequate home instructions were provided. For example, one patient's record documented a patient who had an anterior cervical diskectomy. Physical Therapy evaluated the patient on the patient's second post-surgical day. The evaluation documented the patient would benefit by using a four-footed cane and a home exercise program. The Physical Therapist's discharge note stated the patient had met her goals. She was provided a written instruction called "Instructions After Cervical Surgery" that covered pain control, collar use, activity, movement, positioning and activities of the day.

It was determined that the hospital did provide adequate discharge instructions.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

December 16, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004182

An unnanounced visit was made to the hospital, entering on 11/16/09 and exiting on 11/19/09. During the complaint investigation, surveyors interviewed staff and patients and reviewed medical records, policies, procedures, patient satisfaction surveys and grievance documents.

Allegation #1: The hospital mistreated a patient with unnecessary antibiotics with miserable side effects, padded costs, fabricated diagnoses and ordered unnecessary tests. The hospital failed to respond to a patient's grievance.

Findings: A hospital policy, "Patient Concern, Complaint, and Grievance Process," dated 6/14/09, consistent with regulatory requirements, stated in the resolution of a grievance, the hospital would provide the patient with a written notice of its decision that contained the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.

In reviewing several documented grievances, it was found the hospital followed its policies and procedures for the resolution of grievances. For example, one complaint was verbally reported to the Manager of Patient and Family Relations on 9/23/09.

The complaint related to care a 74-year-old male patient received during a hospitalization between 11/29/08 and 12/07/08. The hospital followed-up on the verbal complaint with a letter of acknowledgement, dated 9/28/09. The letter notified the complainant that the concerns regarding medical staff had been forwarded to the Medical Staff Services Department for review and follow-up. The letter stated the Medical Staff Services Department would contact him directly to discuss concerns further. The letter gave the name of a person to contact for further concerns.

The Medical Staff Services Supervisor documented a phone call with the complainant on 10/19/09. During the phone call the patient was assured his grievance would be reviewed by medical staff peers. If it was determined an element of his care could have been managed differently, physicians involved with his care would be educated accordingly. She also documented referring the patient to the Idaho State Board of Medicine. He reported having already contacted them.

An additional follow-up letter, dated 10/28/09, was sent to the patient acknowledging the complaints. The letter explained to the patient that reviews conducted at the medical staff level were considered peer review. Findings were maintained as privileged and confidential. Peer review information was not available for dissemination, but rather used for quality improvement purposes. The letter stated the hospital took patient concerns seriously and appropriate measures and/or improvement processes would be implemented as appropriate. The letter informed the patient that if he was not satisfied with the actions taken by the hospital, he could seek independent review by contacting the Bureau of Facility Standards or could recontact the hospital for further discussion.

During an interview on 11/18/09 at 9:45 AM, the Manager for Patient and Family Relations, stated the investigation was not yet complete. She stated that after the Chairman of the Peer Review Committee reviewed the complaint and medical record, a peer review meeting would be scheduled.

Allegations related to physician practice, such as tests ordered and medications prescribed, are beyond the scope of regulatory oversight. Although, the hospital's investigation and response may not have been perceived as satisfactory by all complainants, the hospital was found to be in compliance with the minimum regulatory requirements for responding to patient complaints.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: A patient was unable to sleep because of a noisy, rolling bed. Staff did not respond to repeated requests to turn off the bed to allow him to sleep.

Findings: During a tour on 11/18/09 of 7-east Telemetry unit, surveyors interviewed the RN Clinical Supervisor and RN Director of the telemetry unit. The RNs explained the unit had some automatic circulation beds that were perceived by some patients as noisy because there was a sound of alternating air pressure pumping. She explained these beds did not turn off easily and were purchased by the hospital to help reduce and prevent pressure ulcers. After purchasing 35 beds at $14,000.00 per bed, the hospital discovered that some patients didn't like the beds (while other patients really liked them). Unit staff discussed what to do for the patients who didn't like the bed. A decision was made sometime in 2008 to purchase new beds, called "therapeutic mattresses," that were made of foam and did not make noise.

The RNs explained the current hospital practice was to exchange beds if a patient was unhappy with their bed because they found it too noisy or otherwise didn't like it. The last time they received a patient complaint about a bed was in July of 2009. At that time, the bed was exchanged for a different type of bed.

The RNs explained that sometimes they did not learn about patient dissatisfaction with a bed until the day the patient was ready to go home or even after the patient left the hospital and returned a patient satisfaction survey.

In reviewing the hospital record of one 74-year-old male patient admitted on 11/29/08 and discharged on 12/07/08, the only reference found to the patient complaining about his bed was on the day of discharge. The nursing note, dated 12/07/08 at 1:30 AM, stated the patient was unhappy with the self-adjusting bed and was found sitting in a bedside chair. The patient refused to use the bed. Nursing staff provided a cot and put the call light within reach.

During a tour of the unit, the RNs explained most of the automatic circulation beds had been replaced with the "therapeutic mattress." Only one patient could be located on the unit using the "noisy" bed. During an interview with this 71-year-old male patient, he stated the noise did not bother him and he liked the bed. No other patients on the Telemetry Unit at the time of the tour were assigned automatic circulation beds.

A Patient Satisfaction Survey for a 12 month period on the Telemetry floor between September 2008 and August 2009 included 80 respondents. There was an average satisfaction score of 85.06 percent in response to the statement "My room was quiet and restful."

Although it may be true patients had difficulty sleeping in a noisy bed, it appeared the hospital had become aware of the problem and made efforts to correct it.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 25, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004292

An unannounced visit was made to the hospital on 11/16/09 through 11/19/09. Hospital policies, patient grievances and twenty-nine (29) patient records were reviewed. Hospital staff were interviewed.

Allegation #1: The hospital does not keep copies of patients' living wills on file and request patients provide a copy at each visit.

Findings: Ten patient records indicated on the "Admission Agreement," stated the patient had a living will. Ten of ten records contained a copy of the patient's living will. The Hospitals Health Information Manager was interviewed. She stated if a patient brings in a living will, a scanned copy is kept in the patient's medical record. She stated that patients are encouraged to keep a current copy at the hospital so their wishes can be exercised.

It was determined that the hospital did keep copies of patient's living wills on file.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Patients' who were dehydrated were not provided intra-venous (IV) fluids.

Findings: Of the twenty-nine (29) records reviewed, all records contained adequate physician orders for patients who needed medical hydration. The hospital did have a Peer Review process available for complaints of physician practices. While appropriate medical care is addressed in the federal regulatory requirements, the Federal regulations do not address specific physician practices and it is not within the scope of this agency to assess and determine physicians' treatment practices.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Medications were not admistered as ordered.

Findings: Physician medication orders were compared to the administration documentation of ordered medications to patients by nursing staff. Of the records reviewed, it was determined that 100% of the medications were given to patients as directed by the ordering physician.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Hospital staff did not take a patient's blood pressure in approprate spots.

Findings: One patient's record documented the patient had an IV in her right forearm. It was documented that blood pressures were obtained on her right arm on 9/01/09 at 9:38 AM, 11:51 AM, 4:05 PM and 7:45 PM. A hospital staff was interviewed. The staff member was a critical care nurse and taught classes at the hospital on care practices. She stated that blood pressures can be obtained in a sight where an IV is. She stated in some cases this practice cannot be avoided. She said if there is another arm without an IV then that arm would be a better place to obtain a blood pressure, but this was not a written rule and many factors play into this decision. This surveyor researched standards of nursing practices and found the above information to be true.

It was determined that staff did obtain a blood pressure on an arm that had an IV. However, it could not be determined that this was a poor practice that may have or can cause injury to a patient. The practice of obtaining a blood pressure in an arm that has an IV, many variables should be considered and at times this practice cannot be avoided.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #5: Hospital physicians are not involved in discharge planning.

Findings: The hospital's "Discharge Planning Process and Discharge of Patient" policy, dated 11/11/08, was consistent with federal regulations. It stated that the hospital had a process to identify patients, at an early stage (prescreening) that may have post-discharge medical needs. The policy stated patients who were identified in the prescreening process as potentially having such needs, would receive a more comprehensive evaluation to determine what their post-discharge needs were. In interviews with the hospital staff, it was stated that Physical Therapists, Occupational Therapists, Social Workers, Case Managers and Physicians, assessed patients to determine post-hospital needs a patient may have. This was consistent with the hospital's "Discharge Planning Process and Discharge of Patient" policy. Additionally the policy stated that a discharge plan would be developed, implemented and re-evaluated for patients who were identified as having post-hospital medical needs.

Of the records reviewed, it was determined that physicians were involved in patients discharge planning as documented in their progress notes, orders and the physician's discharge summary.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

November 25, 2009

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **November 19, 2009**, a complaint survey was conducted at St. Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004294

Allegation: Emergency Department (ED) staff violated a patient's right to confidentiality and privacy by talking about him in a derogatory and demeaning manner to other staff and placing bets on the patient within hearing distance of the patient.

Findings: During a telephone interview on 11/16/09 at 3:30 PM, the Director of the ED explained the ED routinely sent out "Patient Satisfaction" surveys to patients who had received care in the ED in order to evaluate quality of care and patient satisfaction. One of the statements in the survey included "My privacy was respected in Emergency." Surveyors reviewed a summary of survey results for a 12 month period, ending June of 2009. The standard of success indicated on the summary was 85% in response to the statement regarding privacy being respected. The average results for 12 months exceeded 90%, above the hospital's standard for success.

During a tour of the ED on 11/16/09 at 4:00 PM, it was noted that most patient doors were closed and the ED had consultation rooms available for private conversations.

During an interview on 11/16/09 at 4:15 PM, a Registered Nurse (RN) Charge Nurse in the ED stated staff generally talked to patients in their rooms, closed doors when appropriate and utilized the consultation rooms, if necessary, in order to ensure privacy. He stated staff made efforts to keep their voices down.

All grievances for 2009 were reviewed which consisted of over 500 complaints of varying types. One grievance, dated 9/08/09, documented a complaint relating to ED staff violating patient confidentiality and or privacy during a visit to the ED on 7/04/09. The complaint alleged ED staff talked about the patient in a derogatory manner within hearing distance and placed bets that the patient would fail a drug/alcohol test.

During a phone interview on 11/16/09, the Director of the ED reported having done an internal investigation of the complaint. She reported having interviewed all staff involved with the care of the patient at the time of the alleged violation. Only one staff member, an RN, stated she specifically remembered the patient and the patient's visit to the ED. The RN recalled telling the patient she bet she could successfully start his IV on the first attempt. She denied betting on a blood alcohol level or knowing anything about anyone betting in this manner. The Director stated she reviewed the patient's record and that no blood alcohol level had been ordered on the patient.

Although it was possible privacy/confidentiality was violated, it could not be determined to be true. The trend of the hospital was to respect confidentiality and privacy. Patient Satisfaction surveys indicated a high satisfaction in this area.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

Teresa Hamblin

TERESA HAMBLIN
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

TH/mlw

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

December 8, 2009

Gary Fletcher, CEO
St. Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

CMS Certification Number: 13-0006

Re: Complaint Control # 4373 (EMTALA)

Dear Mr. Fletcher:

To participate in the Medicare program, a hospital must meet the requirements established under title XVIII of the Social Security Act (the Act) and the regulations established by the Secretary of Health and Human Services under the authority contained in §1861 (e) of the Act. Further, §1866 (b) of the Act authorizes the Secretary to terminate the provider agreement of a hospital that fails to meet these provisions.

Your hospital was surveyed November 16-19, 2009, by the Idaho Bureau of Facility Standards (State Agency) based on an allegation of noncompliance with the requirements of 42 Code of Federal Regulations (CFR) § 489.24 Responsibilities of Medicare Participating Hospitals in Emergency Cases and /or the related requirements at 42 CFR § 489.20. After a careful review of the findings, we have determined that your hospital violated:

- **The requirements of 42 CFR § 489.24(a) based on failure to provide an appropriate medical screening exam;**

The deficiencies identified are listed on the enclosed form CMS-2567, Summary Statement of Deficiencies.

The purpose of this letter is to notify you of these violations and advise you that under 42 CFR § 489.53, a hospital that violates the provisions of 42 CFR § 489.20 and/or 42 CFR § 489.24 is subject to termination of its provider agreement. Consequently, it is our intention to terminate St. Lukes Regional Medical Center's participation in the Medicare program. The projected date on which the agreement will terminate is **March 8, 2010**.

You will receive a "Notice of Termination" letter no later than February 21, 2010. This final notice will be sent to you concurrently with notice to the public in accordance with regulations at 42 CFR § 489.53.

You may avoid termination action and notice to the public either by providing credible allegation or credible evidence of correction of the deficiencies, or by successfully proving that the deficiencies did not exist, prior to the projected public information date. In either case, the information must be furnished to this office so that there is time to verify the corrections. An acceptable plan of correction (POC) must contain the following elements:

- The plan of correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

It is highly recommended that the latest completion date in the plan of correction be no later than **January 18, 2010**. Please submit the POC within 10 days receipt of this letter, to the State survey agency and to the following address:

CMS – Survey, Certification, and Enforcement Branch
Attn: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

A credible allegation of correction by the hospital may require a resurvey to verify the corrections. However, when evidence of correction is provided by the hospital, this office must decide whether the evidence of correction is sufficient to halt the termination action. If the evidence is not sufficient in itself to establish that the hospital is in compliance, a resurvey is required for verification of correction.

If we verify your corrective action, or determine that you successfully refuted the findings contained in this letter by proving that allegations were in error, your termination from the Medicare program will be rescinded.

If you have any questions concerning this preliminary determination letter, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

Enclosure

cc: Idaho Bureau of Facility Standards
Office of Civil Rights (OCR)
Complainant

St Luke's
Boise · Meridian

Nationally Recognized for Nursing Excellence

December 17, 2009

Sent via facsimile to (206) 615-2088

Steven Chickering
Kate Mitchell
CMS Survey, Certification & Enforcement Branch
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Re: Complaint Control # 4373 (EMTALA)
CMS Certification Number: 13-0006

Dear Mr. Chickering and Ms. Mitchell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated December 8, 2009, advising us of your determination that St. Luke's Regional Medical Center violated 42 CFR § 489.24(a) based on failure to provide an appropriate medical screening exam when an individual arrived outside our Boise Emergency Department on October 29, 2009.

As you are aware, we submitted a self-report of this event (attached), which described the immediate steps that St. Luke's took to assure compliance with EMTALA requirements per St. Luke's policy.

Enclosed you will find our Plan of Correction, on Form CMS-2567, describing procedures we have implemented to improve the process that led to the deficiency, as well as our plans for ongoing monitoring and tracking to ensure that the plan is effective and that the specific deficiency remains corrected. The plan demonstrates how we are incorporating our actions into our quality assessment and performance improvement program to prevent the likelihood that any similar event will recur. Ms. Dawn Lombardo, Administrator for Emergency Department Services, will be responsible for implementing our Plan of Correction. In support of our statements in the Plan of Correction, we have also enclosed the following evidence:

- EMTALA Talking Points distributed to ED staff (Staff and physician rosters demonstrating compliance with education available upon request)
- Scenario questions for leadership rounding
- Powerpoint used to create the on-line EMTALA training module

St. Luke's Boise Medical Center
St. Luke's Meridian Medical Center
Gary L. Fletcher, CEO
190 East Bannock Street
Boise, Idaho 83712

www.stlukesonline.org

As stated in our self report, this event was disappointing to St. Luke's, the emergency department physicians and staff. Once we became aware of the event, we took immediate action involving hospital and medical staff leadership, along with the Emergency Department staff, to develop and implement the enclosed Plan of Correction. Ms. Mitchell, thank you for allowing us to discuss our case with you on December 10th. We appreciated the opportunity to describe the actions that we had implemented at that time as well as those that were planned. As you will see on the enclosed Plan of Correction numerous additional steps have been completed since our discussion.

Thank you for allowing us the opportunity to respond to your findings. If you have additional questions or concerns with our timeline for response, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff
System General Counsel
General Counsel, Boise/Meridian

Enclosures

cc: Debby Ransom, Idaho Bureau of Facility Standards
Gary Fletcher, CEO, St. Luke's Boise/Meridian
Barton Hill, MD, VP Medical Affairs
Pam Bernard, COO, St. Luke's Meridian
Chris Roth, COO, St. Luke's Boise
Joanne Clavelle, CNO, St. Luke's Boise/Meridian
Dawn Lombardo, Administrator ED Services

PRINTED: 11/25/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiency was cited during the complaint survey of your hospital. The survyeyor conducting the investigation was Gary Guiles, RN, HFS. Acronyms used in this report include: ED = Emergency Department EMTALA - Emergency Treatment and Labor Act MSE = Medical Screening Examination SUV = Sport Utility Vehicle	A 000	In response to the cited deficiency, St. Luke's has implemented a comprehensive plan of correction aimed at improving processes and incorporating ongoing monitoring within our PI program and structure. **Plan for Improving the Process:**	
A2400	489.20(l) COMPLIANCE WITH 489.24 [The provider agrees,] in the case of a hospital as defined in §489.24(b), to comply with §489.24. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records, it was determined the hospital failed to comply with the provisions at CFR 489.24(a). The hospital failed to provide appropriate an MSE to 1 0f 29 patients (# 29), who came to the ED seeking services on 10/29/09. This resulted in 1 patient not receiving a MSE. The findings include: Refer to C2406 as it relates to the lack of an MSE provided to a patient.	A2400	1. A thorough root cause analysis of the event surrounding the cited deficiency was completed on 11/3/09 with involvement from Emergency Department (ED) staff, medical staff, patient safety, legal counsel, Ada County Emergency Medical Services (EMS) and administration. The results of the root cause analysis identified the need for increased formal EMTALA education. **COMPLETE** 2. Immediate counseling of the two staff members involved in the cited deficiency was completed during the week of 11/2/09. The Emergency Medicine of Idaho (EMI) medical director also followed-up with the physician involved in the cited deficiency. (EMI is our contracted provider for the Boise ED, Meridian ED and Eagle Urgent Care.) **COMPLETE**	
A2406	489.24(r) and 489.24(c) MEDICAL SCREENING EXAM Applicability of provisions of this section. (1) In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) "comes to the emergency department", as defined in paragraph (b) of this section, the hospital must (i) provide	A2406	Continued next page... RECEIVED DEC 21 2009 FACILITY STANDARDS	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ...er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 11/25/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A2406	Continued From page 1 an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. The examination must be conducted by an individual(s) who is determined qualified by hospital bylaws or rules and regulations and who meets the requirements of §482.55 of this chapter concerning emergency services personnel and direction; and (b) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section. (2) Nonapplicability of provisions of this section. Sanctions under this section for inappropriate transfer during a national emergency or for the direction or relocation of an individual to receive medical screening at an alternate location do not apply to a hospital with a dedicated emergency department located in an emergency area, as specified in section 1135(g)(1) of the Act. A waiver of these sanctions is limited to a 72-hour period beginning upon the implementation of a hospital disaster protocol, except that, if a public health emergency involves a pandemic infectious disease (such as pandemic influenza), the waiver will continue in effect until the termination of the applicable declaration of a public health emergency, as provided for by section 1135(e)(1)(B) of the Act.	A2406	3. Regular leadership rounds in the Boise ED were implemented on 11/2/09 to answer EMTALA specific questions and scenarios. Participants in the rounding included ED leadership, Education, Patient Safety, Accreditation, the VP of Medical Affairs, the Chief Nursing Officer, and the Meridian Chief Operating Officer. **ONGOING** **Procedures for Improving the Process:** 1. Immediate education was provided to Boise and Meridian ED staff beginning 11/5/09 through the distribution of printed copies of the St. Luke's EMTALA policy and Talking Points. Our policies, including EMTALA, are also available to staff electronically. As of 12/17/09, 100% of ED staff has been provided the policy. **COMPLETE** 2. Beginning 11/6/09 education on the EMTALA policy was provided to all Emergency Medicine of Idaho physicians, nurse practitioners, and physician assistants providing services at St. Luke's Boise/Meridian and Eagle campuses. As of 11/19/09, 100% of Emergency Medicine of Idaho physicians were provided EMTALA education through their leadership staff. **COMPLETE** Continued next page...	

PRINTED: 11/25/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A2406	Continued From page 2 (c) Use of Dedicated Emergency Department for Nonemergency Services If an individual comes to a hospital's dedicated emergency department and a request is made on his or her behalf for examination or treatment for a medical condition, but the nature of the request makes it clear that the medical condition is not of an emergency nature, the hospital is required only to perform such screening as would be appropriate for any individual presenting in that manner, to determine that the individual does not have an emergency medical condition. This STANDARD is not met as evidenced by: Based on staff interview and review of clinical records, it was determined the hospital failed to provide an MSE to 1 of 29 patients (# 26), who came to the ED seeking treatment. This resulted in delayed assessment, stabilization, and treatment of this patient. The findings include: The ED Charge Nurse, who was on duty at the Boise campus on 11/29/09, was interviewed on 11/18/09 at 8:40 AM. She stated, on the evening of October 29, 2009, Patient #29, an adult male, was brought to the circle driveway in front of the Emergency Department by a friend and by two strangers, who had come to Patient #29's aid. She said the friend came into the Emergency Department and requested a "team" of staff to get the patient out of the SUV to be treated. She said Patient #29 had been in a an all terrain vehicle accident. She stated he complained of neck, shoulder, chest, and abdominal pain. She said he had a gash on the side of his head. The Charge Nurse, stated an Emergency Medical Services team had just brought another patient to the hospital by ambulance and she asked them to	A2406	3. A mandatory EMTALA on-line module was deployed on 11/10/09 and assigned to Boise and Meridian ED staff, Security Officers, Patient Registration staff, Clinical Support Unit (float) staff, Administrative Supervisors, and Administrators-on-call. As of 12/17/09, all assigned persons have completed the module with the exception of 3 individuals. These 3 individuals have been suspended until the module is completed. Failure to complete the module will result in termination. **COMPLETE** 4. Additional mandatory in-person EMTALA scenario-based education was provided by St. Luke's general counsel and completed for the Boise ED staff by 12/17/09. Education is planned for the Meridian ED staff during the week of 1/11/10. 5. EMTALA education will continue to be incorporated within New Employee Orientation. Effective 1/4/10, enhanced education will be provided. Continued next page...	

PRINTED: 11/25/2009
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 11/19/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A2406	Continued From page 3 assist with transferring Patient #29 to a stretcher. She said the EMS personnel assessed Patient #29. She stated they decided he needed complete immobilization. She said the EMS personnel called 911 for the fire department to extricate him from the vehicle and place him on a back board. She said the fire department came, immobilized Patient #29, and placed him on a stretcher. The charge nurse said she did not ask Patient #29 if he wanted to be treated at the St. Lukes Regional Medical Center's ED or if he wished to be transferred to the local trauma center's ED. She said Patient #29 was placed in an ambulance and taken to another local hospital which handles trauma cases. She stated he did not receive an MSE. She said a medical record was not originated and the visit was not documented. A corresponding medical record from the other hospital documented the patient arrived there at 8:44 PM on 10/29/09. It documented he was evaluated and admitted as an inpatient for treatment. The hospital did not conduct an MSE on the emergent patient.	A2406	6. General EMTALA education was provided to members of St. Luke's Management Council on 12/17/09 with a cascade "education kit" distributed for use when educating staff. General EMTALA education was also provided to the Medical Executive Committee (medical staff leadership) on 12/15/09 which included distribution of physician specific "Frequently Asked Questions" (FAQs). **COMPLETE** **Integration into QAPI Program:** 1. Progression with this plan of correction and ongoing EMTALA compliance will be incorporated into the organization's Performance Improvement program through the Joint Commission Task Force. **COMPLETE** 2. A monitoring plan will be implemented by 1/10/10 and will be reported at a minimum annually to include: a. Compliance with mandatory education b. Review of transfers out of the ED and patients who have "Left Without Being Seen" for the next three (3) months commencing January 1, and at least annually thereafter. c. Thorough investigation of any concerns received related to potential EMTALA issues. Continued below...	

Responsible Individual:

The individual responsible for implementing the plan of correction described below is Dawn Lombardo, Administrator for Emergency Departments.